New Jersey Office of the Attorney General
Division of Consumer Affairs
Drug Control Unit
124 Halsey Street, 3rd Floor, P.O. Box 45045, Newark, NJ 07101
(973) 504-6351

Controlled Dangerous Substance Registration

Instruction sheet

Enclosed is a Controlled Dangerous Substance (C.D.S.) application, which you are required to submit pursuant to N.J.S.A. 24:21-1 et seq. Registration is required for every person who, or firm that, manufactures, prescribes, distributes, dispenses or conducts research or analysis utilizing controlled dangerous substances.

A New Jersey C.D.S. registration is issued only for a New Jersey location. Be sure to include a $20.00 check or money order, payable to "Treasurer-State of New Jersey." It will take 4-6 weeks to process this application. Your C.D.S. registration will be mailed to the mailing address on file with your professional licensing board.

Please note:

1. If you have a current D.E.A. number in another state and plan to discontinue practice in that state, you may transfer that D.E.A. number to New Jersey by providing the following to the Drug Enforcement Administration, 80 Mulberry Street, Newark, New Jersey 07102, (888-356-1071) *www.deadiversion.usdoj.gov*:

   a. a copy of your New Jersey professional license or a verification letter from the licensing board;
   b. a copy of your New Jersey C.D.S. registration or a verification letter;
   c. a copy of your out-of-state D.E.A. registration; and
   d. a letter requesting an address change to the same address that is on your New Jersey C.D.S. registration.

   A D.E.A. number is only valid in the state listed on the certificate.

2. If you plan to practice in both New Jersey and the state(s) where you currently hold a D.E.A. registration(s), you must also obtain a D.E.A. registration for New Jersey. Please contact the D.E.A. at the address indicated above and complete the New Jersey application.

3. In order to complete the attached application, please note:

   a. A dispenser or prescriber includes medical doctors, doctors of osteopathy, dentists, veterinarians, podiatrists, advanced practice nurses, pharmacies and certified nurse midwives.
   b. Every person or firm handling controlled dangerous substances in New Jersey is required to have both a state and federal registration for that purpose. Federal facilities **do not** require registration.
   c. The address supplied must be current and an actual location where controlled dangerous substances will be stored, prescribed, dispensed, etc. **The address cannot be solely a post office box.**
   d. Dentists may only register at the address for which they hold a current registration issued by their board and at which the C.D.S. registration is required pursuant to 3(c) above.
   e. Individual practitioner applicants (medical doctors, dentists, veterinarians, etc.) must use their own name, not professional association/corporation or partnership information.
   f. Pharmacies are required to use their common trading name (e.g. David Pharmacy), not a business or corporate name.
   g. Dispensers/Prescribers must have an active and current New Jersey professional license number. **Please write in your New Jersey professional license number in "Section B" of the application.**

   - **Advanced Practice Nurses may prescribe controlled dangerous substances. Advanced Practice Nurses may not purchase or maintain any stock supplies of any C.D.S. medication.**

4. If more space is required for your response to any question on the application, please submit a separate sheet of paper identifying the section(s) to which you are responding.

If we can be of further assistance, please call 973-504-6351.

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Newark, NJ 07101

Please type or print firmly with a ballpoint pen.

Initial Application for Registration for Dispenser/Prescriber Mid-Level Practitioner

New Jersey Controlled Dangerous Substances Act
N.J.S.A. 24:21-1 et seq.

Section A: All of the items in this section must be completed.

1. Provide the applicant's name and the place of business (or, if unavailable, the New Jersey residence) to be registered (do not use solely a P.O. box). Registration is provided for New Jersey locations only. If the registration is for a University of Medicine and Dentistry of New Jersey facility, include the department, room number, designation, e.g. M.E.B., M.S.B., etc. The address of record must be your practice location.

Last name | First name | MI
C.D.S. – Responsible Individual

Department | Room number

Street address

City | State | ZIP code

Home telephone number (include area code) | Business telephone number (include area code)

Note: ***Please note that the above-registered address is subject to inspection pursuant to N.J.S.A. 24:21-31 & 32.***

2. Registration requested as: Dispenser/Prescriber ($20)

Make the check or money order payable to: Treasurer - State of New Jersey.

3. Registration requested for: ☐ Schedules II through V

If registration is being requested for only certain Schedules, please indicate which Schedules: ☐ II ☐ III ☐ IV ☐ V

4. (a) Has any restriction been imposed which would affect your privilege to hold a controlled dangerous substances (C.D.S.) registration for Schedule II, III, IV or V substances in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(b) Have you been arrested, indicted or convicted of a crime in connection with controlled substances under federal law or the laws of New Jersey, any other state, the District of Columbia or any other jurisdiction?* ☐ Yes ☐ No

(c) Have you ever surrendered a controlled drug registration or had a controlled drug registration revoked, suspended or denied in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(d) Are there any criminal charges against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

(e) Are you aware of any action now pending against your professional license, or have you been permitted to surrender or otherwise relinquish your professional license to avoid an inquiry or investigation in New Jersey, any other state, the district of Columbia or in any other jurisdiction?* ☐ Yes ☐ No

*** If "Yes," attach a letter setting forth the circumstances of such action.**

Section B: Dispenser/Prescriber (check category)

☐ A.P.N. (Advanced Practice Nurse)
☐ C.N.M. (Certified Nurse Midwife)
☐ P.A. (Physician Assistant)

Section C: Dispenser/Prescriber Identifying Data

1. New Jersey license number _____
(C.N.M.s must include prescriptive authority suffix.)

2. Mid-Level practitioners are required to collaborate with and/or be supervised by physicians, consistent with agreed upon parameters of their respective practices. As concerns the prescribing and/or ordering/dispensing of C.D.S., by affixing my signature below, I affirm that required oversight regarding C.D.S. exists between me and a duly authorized active New Jersey physician licensee. I understand that any C.D.S. ordering/dispensing/prescribing without the required collaborative or supervisory oversight, or engaging in any violation of the statutes or regulations regarding the ordering/dispensing/prescribing of C.D.S. may be deemed professional misconduct or grounds for disciplinary sanction within the meaning of N.J.S.A. 45:1-21.

_____
Applicant's signature

3. *Social Security Number: _____-_____-_____

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certification or license or certificate renewal.

*Pursuant to N.J.S.A. 2A:17-56.44e of the New Jersey child support enforcement law, N.J.S.A. 54:50-25 of the New Jersey taxation law and Section 1128 E(b)(2)A of the Social Security Act, the Unit or licensing agency to which this form is submitted is required to obtain your Social Security number. If you do not have a Social Security number, the Unit must ascertain the reason that you do not have one. The Unit is further obligated to provide your Social Security number to the Director of Taxation, the Probation Division or other agency responsible for child support enforcement and the H.I.P. Data Bank when reporting adverse actions.

You are also being asked to consent, on a voluntary basis, to the use of your Social Security number for the additional reasons stated below.

You are notified that under the Federal Privacy Act (5 U.S.C. Section 552a (note (b)), the Unit or licensing agency to which this form is submitted is requesting the voluntary disclosure of your Social Security number. If you give your consent for the use of your Social Security number, it may be used: to verify the identity of an applicant, to aid in the collection of financial obligations due and owing the Unit or any other state agency, and to aid in the disclosure to state or federal law enforcement and licensing officials and agencies of information obtained in investigations pertaining to licensure or certification and disciplinary proceedings.

I, _____ , ☐ Consent ☐ Do Not Consent
Applicant's signature

to the use of my Social Security number for any of the additional purposes set forth above. I understand that my consent is voluntary and that if I do not consent, no adverse action or inference will be taken or drawn.

Section D: Certification

I, _____ in making this application for registration, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny registration or to withhold renewal of or suspend or revoke a registration issued by the Drug Control Unit.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for registration. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Drug Control Unit.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____
Applicant's full signature | Date

For State Use Only

C.D.S. number_____ Effective date _____ Expiration date _____

Retain a copy for your records. Mail the original and one copy with your fee to the above address.

DDC-25
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